

**Connecticut Technical High School System--Health History, Emergency Contact & Non-Prescription Medication Form**

Student Name \_\_\_\_\_ Grade \_\_\_\_\_ Shop \_\_\_\_\_ Date of Birth \_\_\_\_\_ Male  Female

**Lives with:**  Both Parents       Mother       Father       Legal Guardian: \_\_\_\_\_  Other: \_\_\_\_\_

Home Address: \_\_\_\_\_ Town \_\_\_\_\_ Zip Code \_\_\_\_\_

**Emergency Contact Information:** Names & grades of siblings attending this School: \_\_\_\_\_

**Mother/Guardian's name:** \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Town: \_\_\_\_\_ Zip: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Name of Employer \_\_\_\_\_ Work Phone: \_\_\_\_\_

Mother/Guardian's Email Address: \_\_\_\_\_

**Father/Guardian's name:** \_\_\_\_\_ Home Phone: \_\_\_\_\_

Address: \_\_\_\_\_ Town: \_\_\_\_\_ Zip: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Name of Employer \_\_\_\_\_ Work Phone: \_\_\_\_\_

Father/Guardian's Email Address: \_\_\_\_\_

**If parent or guardian cannot be reached call:**

1) Name: \_\_\_\_\_ Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_ Relationship \_\_\_\_\_

2) Name: \_\_\_\_\_ Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_ Relationship \_\_\_\_\_

3) Name: \_\_\_\_\_ Home # \_\_\_\_\_ Cell # \_\_\_\_\_ Work # \_\_\_\_\_ Relationship \_\_\_\_\_

Family Doctor's Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Family Dentist's Name: \_\_\_\_\_ Phone # \_\_\_\_\_

Hospital Preference\*: \_\_\_\_\_

\*In the event of an emergency we will notify emergency personnel of your hospital preference. We cannot guarantee transport to a specific hospital.

**Parent/Legal Guardian Signature:** \_\_\_\_\_ Date: \_\_\_\_\_ **(Other Side Must Be Completed)**

Student's name: \_\_\_\_\_ Date of Birth \_\_\_\_\_ Shop \_\_\_\_\_

Is your child covered by Medical Insurance?  Yes  No

Medications taken at Home (**daily or as needed**): \_\_\_\_\_

Medications taken at School: \_\_\_\_\_

Allergies (**food, medication, insects, latex, other**):  No  Yes \_\_\_\_\_ EpiPen needed?  No  Yes

Asthma  no  yes If yes,  mild  moderate  severe  exercise induced? Inhaler needed:  Yes  No

---

I, \_\_\_\_\_ (Parent/Guardian name) give the school nurse permission to speak with my child's doctor about allergy and/or asthma management. Parent/Guardian Initials: \_\_\_\_\_ Date: \_\_\_\_\_

---

**My child has or has had:**  Diabetes  Seizures  Brain or neurologic problem  Head injury or concussion  Bleeding disorder or bleeding that's very hard to stop  Stomach or intestinal problems  Heart problems  Bone or joint problems  Glasses  Contacts  Hearing Aid(s)  Activity or gym restrictions (**requires doctor's note**)  Problem with overeating or weight gain  Problem with under-eating or weight loss  ADD, ADHD or hyperactivity  Depression  Other psychological problem  Frequent absences from school  Problems in school  Problems at home  Other medical problem (s) \_\_\_\_\_

Please provide more information for any box checked above: \_\_\_\_\_

---

**Permission to give Non-Prescription Medication:** The School Nurse has permission to administer the following medications as ordered by the school district's Medical Advisor on an "as needed" basis during the school day.

For headache (without head injury), fever, menstrual cramps, dental discomfort, or muscle aches:

Acetaminophen (generic Tylenol)  Ibuprofen (generic Advil or Motrin)

For "upset stomach" or heartburn:

Chewable Antacid (generic for TUMS)

**I do not want my child to receive any of these medications**

Parent/Legal Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**(Other Side Must Be Completed)**